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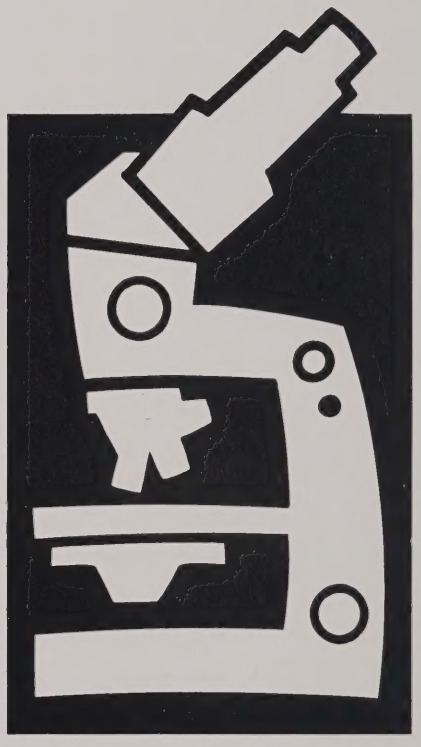

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THE
Hampden Hippocrat
FALL 1995

In This Issue

Hampden Committee Activities 3

President's Message 4

Mental Health Services In An Integrated Delivery System: 6

In Memoriam 8

Community United Way 9

1995 Annual Meeting Of The House of Delegates 10

MMS Executive Briefs 17

New Members Welcome 21

The official bulletin for The Hampden District of the Massachusetts Medical Society. Founded in 1942 by Edward P. Bagg, Jr., M.D. and William A. R. Chapin, M.D.

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From The Editor

The start of a new season of Society activity seems an appropriate time to get some input from our readers regarding the Hippocrat. It would help the editorial staff to know which aspects of the publication are important and which are read, as well as what additional content is desired. A simple survey is included overleaf from the District Meeting coupon. Please take a few moments, whether you plan to attend the meeting or not, and use the survey to communicate with us.

The areas listed on the survey include everything from regular to proposed features, and we remain open to your contributions even if they fit none of the categories.

Dennis S. Gordan, M.D.
Editor

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Hampden Committee Activities

The **PUBLIC HEALTH COMMITTEE** met in May and June. **Dr. Sheffield** reported on the training session he had completed for the Junior Achievement Sixth Grade Trade Around The World Program. **Dr. Barnshaw** reported that the Springfield YMCA is sponsoring some wonderful programs for needy children in the area. The committee's interest prompted them to invite Mr. Stephen Clay, Director of the YMCA, to their June meeting, where he presented the committee members with an indepth review of the YMCA's role in the community. He reported on the YMCA Teen Center. The Center runs a program from 6:00 to 9:30 p.m., Monday through Thursday, for any child ten to sixteen years of age. Activities include basketball, swimming, ping pong and pool tables. The members must attend all educational lectures in order to participate in the program. The "Summer in the Park" program runs Monday through Saturday from 9:00 a.m. to 4:00 p.m. at the Emily Bill Park Playground, with a field trip scheduled once a week. The YMCA also runs the Camp Weber Program on Mondays, Wednesdays and Fridays from 6:00 to 9:30 p.m. at the West Springfield Campsite. Campers pay a $20 registration fee, which can be earned by doing light jobs around the camp. Mr. Clay also spoke about the Youth Development Community Block Grant. This is a $2 billion federal program to coordinate and expand community-based youth development programs for children aged 6-18 years. The YMCA would like to use the money to set up a North End Teen Center. The Public Health Committee members offered to send letters of support for the grant to Representatives Neal and Olver.

The **MEDICO-LEGAL COMMITTEE** met in June to continue planning for the Fourth Annual Forum. It will be held at the Delaney House in Holyoke on Thursday, November 2, 1995. The title has been changed to, "The Medical, Legal and Societal Impact of Managed Care". The format will be a round table type discussion with a moderator. Panelists will be asked to represent the positions of Medicine, Health Administration, Government, Law and Insurance.

The **EXECUTIVE COMMITTEE** met in May and June. **Dr. Papale** reported on the House of Delegates meeting held on May 18-19, 1995. The Resolution on District Societies was sent to the Board of Trustees for further study. The single payer system resolution was modified to reaffirm Mass Medical Society support for pluralistic financing with a study of existing single payer systems to be conducted. Physician assisted suicide was opposed.

Dr. Papale also reported on the Public Hearing he and **Dr. Stephen Metz** attended on June 8, 1995, concerning Medicaid Waiver. Indications are that some low-income populations may lose their eligibility for coverage under the Medicaid plan. Also, many children from low income families will no longer receive coverage from the Children's Medical Security Plan. Dr. Papale and Dr. Metz were there representing Mass. Medical Society, as well as Hampden District. Mass. Medical Society is asking to have the opportunity to work with the Blue Ribbon Commission to work on these problems.

The Awards Ceremony for our Annual Poster Contest was held at Symphony Hall on June 6, 1995. A total of 54 schools in Hampden and Hampshire Counties participated. The winning posters will be used as covers for the Hampden Hippocrat.

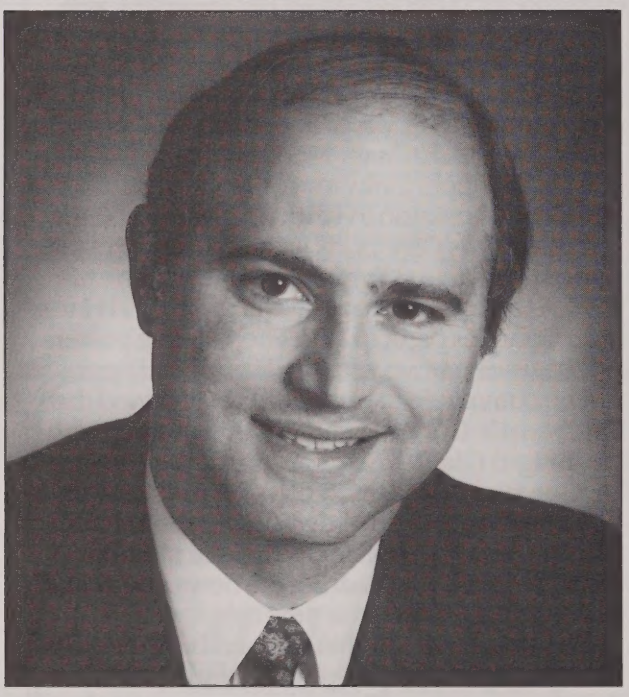
The committee members were informed that **Dr. Dennis Gordan** will be joining forces with **Dr. Brigid Glackin** as co-editor of the Hippocrat. Dr. Gordan specializes in physical medicine and rehabilitation at the Weldon Center for Rehabilitation at Mercy Hospital. Committee members were pleased upon hearing the news and wish Dr. Gordan all the best in his new role.

The Executive Committee members reviewed the Annual Financial Report with our auditor at their June meeting. The report was accepted as presented.

The Girl Scout Mentor Program was held on June 29, 1995. The program titled, "Girl Scouts of Today-Physicians of Tomorrow", was a great success. Women physicians volunteered to take a Girl Scout as an "intern" for the day. The Girl Scouts met with their physicians at an orientation breakfast at Mercy Hospital Deliso Center. Each spent the day with a physician and then both returned to the Deliso Center for a reception. Both the Girl Scouts and the physicians were given an opportunity to relate their experiences of the day. Everyone had a good day and learned a lot, including parents of the Girl Scouts, who were invited to both the breakfast and reception. Evaluations from both physicians and Girl Scouts were positive and it is hoped that this program will become an annual event. ■

Are We Ready For Single Payer?

The annual meeting of the Massachusetts Medical Society usually engenders healthy debate. The May, 1995 meeting was no exception. Although many potentially controversial resolutions were presented, including a resolution



John Papale, M.D., President

concerning physician assisted suicide, none created as much interest as a resolution endorsing a single-payer system for financing health care. The advocates of this system point to the Canadian system as a model. All citizens would be insured, the system would be financed through taxes, and physicians would be paid on a fee-for-service basis. Universal coverage would be guaranteed, and all bills would be paid through one system. The benefits of this system are extremely enticing. Can you imagine being paid for *every* patient that visits you? How wonderful it would be to deal with only one payer, instead of the hodge-podge of insurance plans we now have to tangle with!

In conference committee, this resolution created more than three hours of debate. The proponents pointed to the lack of universal coverage that currently exists in our state and our country, the tremendous profits of private health care delivery companies (e.g. U.S. Healthcare), the waste of non-profit insurers, and the current administrative hassles and costs we all currently encounter. There was agreement that our current system is imperfect, but many factors need to be weighed in any single-payer system.

Most health care experts consider at least three factors when considering any reform of our current system: universal access (or, if not universal, what percent of the population would be covered), quality of care, and cost. By definition, a single-payer system would be designed to permit coverage for all of our citizens. In a manner similar to public education, all Americans, by birthright, would have access to health care. The issues of quality and cost, however, are in no way addressed by this system.

Single-payer systems are not necessarily cost-efficient. We currently have many "single-payer" systems deeply ingrained in our culture. Public education, defense contracting, public works projects, and the U.S. Postal Service are all examples of single payer financing. Yet, we are now bombarded with arguments for charter schools (in Springfield), privatization of school systems

(in Hartford), and uncontrolled expenditures in our military services. For example, before a single B-1 bomber reached the assembly line, there were $50 billion spent on development alone. The cost to manufacture each aircraft (several hundred million dollars) needs to be added to these fixed development costs. I continue to be amazed that private companies (e.g. UPS or Federal Express) can not only compete with the Post Office but also often beat the Postal Service at its own game. These "upstarts" compete against a system that is over 200 years old, has branches everywhere, can never go bankrupt, and has its roots in the U.S. Constitution. Yet, these private companies are unphased, and despite recent postal service innovations, we all know who to use "when it absolutely, positively has to be there overnight". These examples are not used to demean our public institutions, but merely to point out that public and private systems both serve an important function in our free-market society. They can not only co-exist, but also complement each other. Bear in mind, however, that a single payer system (i.e. the Canadian system) would virtually eliminate *any* competing payment mechanism, whether it be complementary or competing.

Quality of care is another issue that is not guaranteed by such a system. However, this point is more difficult than cost to discuss in an entirely objective fashion because many of our quality measures still need to be defined. Nonetheless, the flourishing of private systems juxtaposed against our public systems begs us to answer the question: why would anyone spend *more* money on private services (e.g. private schools or postal services) if there was not at least a perception of quality?

Perhaps, most important in this debate is the choice we now have amongst competing health plans and hopefully, the freedom to choose our physicians. As citizens in the "land of the free", we can choose our job, religion, school system, home, food, and automobile. Is it possible we should have *no* choice of health systems? This is currently the case in Canada, with the paradoxical caveat that some citizens *choose* to travel to the United States for certain services. It seems incomprehensible to me that as members of a "free society" we may not have, at a minimum, a basic choice between a public and private system when basic necessities such as health care are concerned. I can have my choice of the nonessentials in life, but not my choice of doctors? Nonsense!

After the debate, I had the opportunity to discuss my feelings regarding the pitfalls of any single-payer system with one of its leading proponents. I used the above examples as potential dangers in such a system. I asked him to give some examples of single-payer systems he felt were successful. He immediately named the Medicare system, Social Security, and Head Start as three examples of single-payer programs that work. I pondered his response for a long time and continue to wonder whether these systems support his argument. Regardless, if you feel the same as I do, you would then agree with the decision of the Massachusetts Medical Society and conclude that we are not yet ready to support a single-payer system.

The complex issues regarding health care financing continue to require further scrutiny. Meanwhile, we should all continue to closely follow the cost of the Canadian system, the access to care its 26 million people may encounter, and the quality of the services provided. ■

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Mental Health Services In An Integrated Delivery System:

The Interface With Primary Care

by Benjamin Liptzin, M.D., Chairman, Department of Psychiatry, Baystate Medical Center
Professor and Deputy Chair, Department of Psychiatry, Tufts University School of Medicine

As healthcare institutions and providers try to adapt to changes in the payment mechanisms for healthcare services, one approach has been to try to develop integrated delivery systems that can accept capitated contracts for a covered population. What is the role of mental health services in such a system and why is it important to think about it?

The following are some reasons for the importance of mental health services:

1. Mental Disorders and Substance Use Disorders Are Very Common. The Epidemiologic Catchment Area Study funded by the National Institute of Mental Health estimated that 28.1% of the adult population had a diagnosable alcohol, drug abuse or mental disorder.

2. Patients With These Disorders Frequently Present to a Primary Care Provider. The same study found that less than half of those with a diagnosable disorder received any health services for their condition in a 12 month period. Of those who received treatment, the majority were treated by general medical providers and not mental health specialists. Conversely, another study found that 25-30% of primary care patients have some psychiatric disorder.

3. Often the Mental/Substance Abuse Disorder is Unrecognized. A study of primary care internists found that while they were good at picking up major depression, they often missed the diagnosis of chronic depression, minor depression, or mixed anxiety/depression. Similarly, less than half the patients with a current depression who visited a general medical care provider had their depression detected.

4. Even if Recognized, the Mental/Substance Abuse Disorder is Often Undertreated. In a large study of a mixed-model HMO, medical patients reported high levels of anxiety. In 56% of these patients, the symptoms were unrecognized and untreated.

5. If Mental/Substance Abuse Disorders are Undertreated it Leads to Increased Medical Utilization and Functional Impairment. In the above HMO study, patients with untreated anxiety reported significantly worse functioning on both physical and emotional measures than "not anxious" comparison patients. In fact, untreated anxious patients reported reduced functioning levels within ranges expected for patients with chronic physical diseases such as diabetes and congestive heart failure. Another study found that distressed high utilizers of primary care had an extremely high prevalence of current or lifetime panic disorder. The Medical Outcomes Study found that in a two year period the limitations in functioning and wellbeing associated with depression were similar to or worse than those attributed to chronic medical illnesses such as diabetes, hypertension, recent myocardial infarction, and/or congestive heart failure.

6. Appropriate Treatment of Mental/Substance Abuse Disorders including Access to a Mental Health/Substance Abuse Specialist May Cost Less Overall. A randomized controlled trial of a psychiatric intervention for somatizing patients found a significant increase in physical functioning in the year after the intervention and a 33% reduction in their annual medical care charges.

Analysis of data from the Medical Outcomes Study concluded that more appropriate care for depression (increased counseling, use of appropriate antidepressant medications, or avoidance of regular minor tranquilizer use) would improve functional outcomes. The authors suggest that the trend away from mental health specialty care and towards general medical provider care may reduce costs in the short run but worsens outcomes and does not increase the value of health care spending in terms of health improvement per dollar spent.

In summary, appropriate treatment of mental/substance use disorders is essential in an integrated delivery system. There needs to be close collaboration between mental health specialists and primary care clinicians to assure appropriate recognition and treatment. In the long run, this should help reduce costs by reducing unnecessary or inappropriate medical care and should improve patient functioning and well-being. ■

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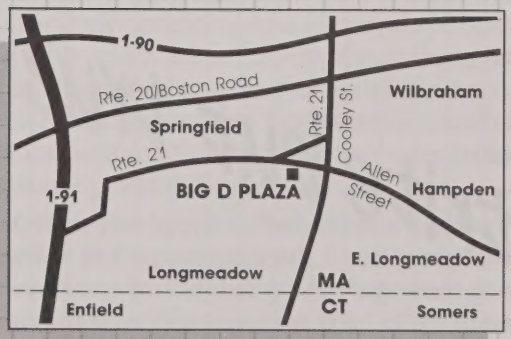

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In Memoriam

Dr. Walter J. Wiese, 101, of Longmeadow, a retired eye, ear, nose and throat specialist, died Friday, August 4 at home. He retired from private practice in 1963.

Born in Meriden, CT, he attended local schools and graduated from Yale University in 1916 and Harvard Medical School in 1923.

He interned at King's County Hospital in Brooklyn, NY

He moved to Springfield and was on staff of Springfield Hospital.

He was later appointed chief of the Department of Ear, Nose and Throat at Springfield Hospital. He was the foremost Ear Surgeon in Massachusetts at that time.

He was the oldest communicant of Saint Andrew's Episcopal Church in Longmeadow and was a member of the Springfield Rotary Club.

His wife, the former Ruth Hastings, died in 1960. He leaves a daughter, Ellen P. Wiese of Longmeadow; two nephews, Robert Wiese of Alliance, Ohio, and William Wiese of Albuquerque, NM, and a cousin, Dorothea Schmelzer of New Town, Penn. ■

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- Flexible child care before, during, and after school through agencies like Springfield Day Nursery and local community centers in Westfield, West Springfield, Chicopee and the North and South Ends of Springfield to help relieve the added stress working parents can sometimes feel juggling full-time parenthood and employment.
- Wellness programs at the Springfield and Westfield YMCA's that focus on proper diet, nutrition, and exercise to help seniors stay healthy and energized;
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Despite the facts presented, I'm sure there are still some naysayers and skeptics who question the connection between a healthy contribution and a healthy community. And admittedly, your contribution to the Community United Way may not improve the quality of life in our community overnight. Yet, by giving employees and patients access to information on Community United Way funded programs and services and ensuring these programs remain available with our continued financial support, we will see healthier residents, and in turn, a healthier community. ■

Howard M. Ledewitz, M.D.
1995 Chairman, Physicians Community United Way of Pioneer Valley

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1995 Annual Meeting Of The House of Delegates

by Alan M. Harvey, M.D.,MBA

Introduction

- The AMA House of Delegates met in Chicago, June 18-22, 1995
- The House is composed of 432 voting delegates, representing state medical associations, national medical specialty societies, AMA Sections, the Armed Forces, and the U.S. Public Health Service.
- The House agenda contained 87 reports and 233 resolutions.
- Mr. Newt Gingrich, Speaker of the U.S. House of Representatives, spoke to and answered questions on Medicare reform from the House of Delegates via a live satellite hookup.

The House considered many diverse issues in socio-economics, science, medical education and public health. Following are the highlights of the major issues considered at the meeting:

Medicare Transformation

The Board of Trustees submitted a comprehensive report reviewing the current status of the Medicare transformation debate, outlining current strategy and policy approaches on this issue, and recommending policy changes to enhance advocacy efforts in this important legislative initiative.

The House of Delegates was clearly focused on the political debate surrounding the restructuring of the Medicare program to avoid the looming financial crisis. The Board stated that "Medicare must be transformed by reducing the growth rate of program expenditures and by fully funding its promise to beneficiaries. These goals cannot be met through failed policies of the past. They must be achieved through shared sacrifice." The AMA's goals are to:

1. Enhance personal responsibility and cost consciousness.
2. Enhance intergenerational equity in financing.
3. Enable and facilitate price competition among providers.
4. Reduce regulatory and administrative complexity.

The House of Delegates debated this issue extensively, both in the Reference Committee and on the House floor, amended the Board's recommendations and adopted the following policy statements to guide the Association during the course of this legislative battle:

1. *That the AMA reaffirm that the fundamental goal of transforming Medicare should be to assure the health of the elderly and disabled populations.* Patients must have access to high quality medical services. The best value in medical care can be achieved by ensuring that the medical profession has a central role in the design and implementation of a new Medicare program. Patients must also receive timely and accurate information on the necessity and important aspects of Medicare transformation.
2. *That, in the context of changes that enhance the fiscal solvency of Medicare, increase beneficiary choice. and encourage program privatization, AMA policy should accept a defined contribution by the federal government toward the purchase of private health care coverage by Medicare beneficiaries.* This defined contribution should equal the national average risk adjusted actuarial value of the government Medicare contribution for individuals retaining traditional Medicare coverage. The value of this contribution should reflect the cost of access to needed health care, including preventive services, and the need to establish the fiscal solvency of Medicare.
3. *That AMA policy should include approaches that restructure Medicare beneficiary*

deductibles. coinsurance, premiums, and Medigap insurance to enhance the effectiveness of cost sharing. increase patient choice. maintain beneficiary financial protection, and reduce costs to Medicare and beneficiaries from Medigap coverage. This restructured cost sharing should include appropriate incentives for patients to seek and receive preventive services,

4. *That, consistent with current AMA policy, Medicare should eliminate price and regulatory controls on charges and payments, including limiting charges for physicians' services and the flawed Medicare Volume Performance Standard.* Consistent with current policy, these controls would be replaced by a competitive pricing system in which physicians would set and disclose to patients their own fees and/or dollar conversion factor for the RBRVS and Medicare would set its conversion factor, considering both the budget and patient access to care. A similar approach should be implemented for Part A of Medicare.
5. That, current policy on Medicare funding of graduate medical education be replaced to state, *"In the context of an all-payor funding pool for graduate medical education, Medicare contributions for direct and indirect costs of graduate medical education should be reduced consistent with the need to improve Medicare fiscal solvency and with the proviso that these funds be replaced, in aggregate, with contributions from the all-payor funding pool sufficient to maintain adequate funding for graduate medical education."* Moreover, the all-payor funding pool should be administered by a public private sector partnership.
6. *That AMA policy should accept a gradual reduction in the number of PGY-1 residency positions funded through the Medicare direct and indirect medical education adjustments.*
7. *That, consistent with existing policies, patient and physician interests in high-quality care should be protected through non-intrusive regulatory approaches and existing or enhanced private sector efforts.*
8. *That the Board submit a progress report on Medicare transformation, providing details on mechanisms and criteria by which the*

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Delegate's Report

Continued from previous page

Medicare defined contribution would be established initially and updated over time to take into consideration patient access. changing demographics. and the effect of inflation.

Medicaid

The House considered two resolutions regarding legislative proposals to reform the Medicaid program by turning it into a Block Grant Program. The House adopted a substitute resolution that called on the AMA to:

1. Seek to assure that any restructuring of Medicaid, including block grants, preserve the safety net function of Medicaid.
2. Seek to identify and support alternatives that promote flexibility and innovation in the Medicaid program, such as programs allowing individuals to buy-in to Medicaid on a sliding scale based on income level, while ensuring quality and improving access to health care services.

The Criminalization of Health Care Decisionmaking

Two resolutions were introduced regarding the current trend among courts and state legislatures to attempt to criminalize health care decisionmaking. The House adopted a substitute resolution asking the AMA to:

1. Oppose the attempted criminalization of health care decisionmaking especially as represented by the current trend toward criminalization of malpractice; it interferes with appropriate decision making and is a disservice to the American public.
2. Develop model state legislation properly defining criminal conduct and prohibiting the criminalization of health care decisionmaking, including cases involving allegations of medical malpractice, and implement an appropriate action plan for all components of the Federation to educate opinion leaders, elected officials and the media regarding the detrimental effects on health care resulting from the criminalization of health care decisionmaking.

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- malpractice claims due to inadequate informed consent?
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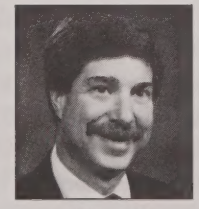
- providing for the orderly disposition of your practice in the event of death or disability?



Attorney
Arthur W. Price

Arthur W. Price and Michele J. Feinstein, partners in Cohen, Rosenthal, Price, Mirkin & Wernick, have more than twenty-five years of combined experience in representing area physicians in their practices and individually. They counsel solo and group practices in their day to day businesses as well as in their planning for growth or extraordinary concerns. They also advise physicians on personal and family problems.

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Attorney
Michele J. Feinstein

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Professional Liability

The House heard testimony highlighting the need for federal professional liability reforms that would: (1) establish a cap on liability awards and (2) preempt state laws or regulations that prohibit such a cap. However, the testimony recognized the equally compelling need to protect existing or future state caps on liability awards which are *lower or more comprehensive* than those enacted on the federal level.

The House adopted a substitute resolution calling on the AMA to:

1. Support professional liability reform on the federal level that will preempt state constitutional, statutory, regulatory and common laws that prohibit a cap on liability awards.
2. Support federal legislation which shall not preempt state constitutional, statutory, regulatory and common laws that set caps or other restrictions on liability awards which are lower or more comprehensive than the caps on liability awards established by such federal legislation.

Tort Reform And The Tobacco Industry

In a related action the House adopted a policy asking the AMA to:

Oppose any provision of tort reform legislation that would give exclusion from liability or special protection to tobacco companies or tobacco products.

Physician Assistants and Nurse Practitioners

The Board submitted a report that reviewed the professional relationships of physicians with nurse practitioners and with physician assistants with respect to AMA policy, definitions, and the views of other organizations. The House revised the model guidelines and adopted suggested guidelines for physician/physician assistant practice.

Mandatory Rating System for Content of Musical Lyrics and Videos

One resolution, co-sponsored by the Florida and Montana delegations, received wide media coverage. The resolution pertained to certain music that is popular with a significant portion of the younger population that is characterized by inflammatory lyrics that denigrate women as well as promote and incite violence, brutality and aggression.

The House adopted a substitute resolution directing the AMA to:

1. Continue to publicly express concern about

Continued on next page

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Delegate's Report

Continued from previous page

the potentially negative impact that destructive themes depicted in the lyrics of certain music may have on the nation's youth.

2. Reaffirms existing policy which expresses concern about themes in some musical lyrics, encourages physicians and parents to be aware of possibly destructive themes in some music.
3. Offer to work with the music recording industry to develop a mandatory rating system.

Food and Drug Administration

The House considered an informational report from the Board and four resolutions on various proposals to reform the Food and Drug Administration. Many delegates commended the FDA for keeping unsafe and ineffective medical products from being marketed. Others spoke about the length of time required for a drug to be approved.

The Board report was amended by the addition of three policy statements that read as follows:

1. That the AMA reaffirm its policy to continue to monitor and evaluate proposed changes in the FDA and to respond as appropriate.
2. That the AMA continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA.
3. That the AMA continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers, pharmaceuticals, and devices to try to resolve the concerns of physicians and to support the FDA initiatives of potential benefit to patients and physicians.
4. That the AMA continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively.

Opposition to Payment for Prescription Switching

A resolution, introduced by the South Dakota Delegation, addressed the issue of pharmaceutical companies notifying pharmacists that they will pay to the pharmacist a fee to provide counseling services regarding their product, causing patients to ask their physicians to change their prescriptions to one recommended by the pharmacist. In turn, the pharmacist receives a counseling fee from the pharmaceutical company.

The House of Delegates adopted a substitute resolution strongly denouncing this practice, calling on the AMA to:

1. Reaffirm policies which oppose the practice of therapeutic substitution by pharmacists.
2. Denounce the practice of pharmacists recommending to patients that prescriptions be changed to products manufactured by companies which pay pharmacists upon completion of such prescription-switching.
3. Denounce the practice by companies of offering payments to pharmacists in exchange for recommending changes in prescriptions.
4. Reaffirm current policy which opposes the practice of prescription-switching for payment by pharmacists.
5. Denounce the practice of medicine by pharmacists.
6. Notify the American Pharmaceutical Association (APhA) of these actions and encourage the APhA to adopt similar policies.

Point of Service

The Council on Medical Service submitted a comprehensive report entitled, "Health Benefits Plans and 'Point of Service'" that reviewed current policy that provided a basis for the AMA's Patient Protection Act and recommended a policy change. The modification would clarify the Council's original intent and current belief that all health plans or sponsors of such plans that restrict patient choice should be required to offer an optional Point of Service feature at the time of enrollment and, at least, for a continuous one-month period annually thereafter.

The House adopted the Council's recommendation and asked the AMA to review available data on the cost of options for point of service and evaluate the necessity for an AMA sponsored study of the costs of options for point of service and report back to the House at the 1995 Interim Meeting.

Conclusion

AMA House meetings provide a unique educational opportunity and I would encourage you to attend and participate. Any member of the AMA may present testimony at the Reference Committee hearings and, of course, corridor discussions on the issues provide ample opportunities to get your views across.

If you cannot come to the meeting, you can still be represented through your delegate. Let your delegation know your opinion. You can also prepare a resolution and request that it be submitted to the AMA House of Delegates. Your delegates know how to best carry forth your point of view.

Thank you for giving me this opportunity to present this report.

I will be happy to respond to any questions. ■

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Department of Neurology
Memorial Sloan-Kettering Cancer Center

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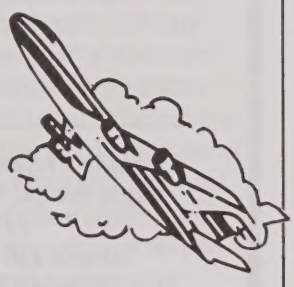

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MMS Executive Briefs

DEA Fee

AMA Office of General Counsel informed us that DEA can keep its fee at $210, and physicians, must pay that amount, until further notice, until the increase is ruled unjustified. If the fee is lowered, reimbursements are to be issued.

MASS To Lose $13 Billion If Cuts Made In Medicare, Medicaid

A report released last week warned that *the Massachusetts economy could lose $13 billion* and 71,000 health sector jobs over seven years if Congress's proposed cuts in Medicare and Medicaid become reality. "The Economic Impact of Medicare and Medicaid Cuts on Massachusetts" report, released on August 8 by the MMS and other members of the Coalition for Responsible Medicare and Medicaid Reform, examined the potential impact of federal health program cuts on the Commonwealth's health care industry, cities and towns, graduate medical education system, and biotechnology companies. The Howell Group, which conducted the study for the Coalition, warned that $452 billion in Medicare and Medicaid cuts would "strike at the heart of the state's knowledge-based economy and seriously weaken one of the most mportant and stable sources of employment in the Commonwealth." The Coalition report also found that Medicare/Medicaid cuts could indirectly cost 165,000 jobs and seriously affect more than a dozen large cities and towns (including Boston, Brockton, Fall River, New Bedford, Springfield, and Worcester).

While Congress remains on summer recess, Republicans and Democrats are visiting home districts to discuss Medicare and Medicaid cuts with constituents. Although the GOP's Medicare plan is still under wraps, Republican legislators are continuing to describe the changes they see as critical to Medicare's future, particularly the use of vouchers, medical savings accounts (MSAs), and a greater emphasis on managed care plans, and other cost control measures. State governors are discussing the potential effects of converting Medicaid funding into block grants, with particular concerns from states that expect substantial increases in their Medicaid populations.

The Coalition is also working during the Congressional recess to meet with legislators about Medicare/Medicaid funding issues, and will

Continued on next page

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MMS Executive Briefs

Continued from previous page

meet with U.S. Representative Peter Torkildsen (R-Sixth District) this week. U. S. House of Representatives Minority Leader Richard Gephardt (D-MO) is traveling to several states to hear local concerns, and will meet some of U.S. Representative Martin Meehan's (D-Fifth District) constituents at Marlboro Hospital on August 15.

Drive-Through Delivery Bill Clears Committee

The Joint Committee on Insurance late July approved Senate 1926, the bill that would require *insurance companies to provide minimum hospital stays after childbirth.* The MMS had testified in strong support of the bill in early July.

The House is expected to take up the bill in the fall when it returns from summer recess; and also to act on other MMS bills, including the Society's physician profiling legislation, which cleared the Joint Committee on Health Care earlier this year. The MMS inline skating bill, requiring inline rental businesses to make protective wrist, elbow and knee guards as well as helmets available to their customers who rent inline skates, is expected to come before a legislative committee for public hearing. Deliberations by the Blue Ribbon Commission on Health Care are also continuing. In other legislative news, Representative John McDonough (D-Boston) was elected as co-chair of the Joint Committee on Health Care. He replaces Representative Carmen Buell, who resigned her seat to relocate to North Carolina.

Physicians Advised on Network Solicitations

The MMS (as well as other state medical societies and the American Medical Association) continues to receive inquiries from members concerning solicitations from certain managed care brokerage firms to join physician "networks." Such entities include Healthcare Networks of America, Inc. (HNA), Allied Group Network, Inc. (AllNet), and Health Designs, Inc. These organizations typically use high-pressure or deadline-oriented sales tactics to elicit an "enrollment" fee from a physician before the physician is provided any materials. Physicians who ultimately choose not to enroll have reported difficulty in obtaining refunds.

Physicians should be cautious when making a substantial financial commitment to any health plan or network. Physicians are advised to obtain sufficient information about a network's sources of patients, seek references from physicians in similar specialties or geographic area, and review the agreement thoroughly before submitting any money. Physicians should also seek legal counsel concerning any questions about their rights and responsibilities under a network contract. For more information, contact the Department of Legal Services at MMS headquarters.

Bits And Pieces...

Physicians who provide pediatric immunizations should return their enrollment form for the Vaccines for Children program to the Massachusetts Department of Public Health (DPH) as soon as possible. Effective in August, the DPH will be unable to supply vaccine to providers who have not enrolled in the program. For more information or to obtain an enrollment form, contact the DPH at (617) 983-6800. ... A Coronary Artery Disease Prevention pilot program offered by the State John Hancock Insurance Plan (on behalf of the Group Insurance Commission) is now accepting patient referrals. The program, designed by national experts, is aimed at reducing risk of coronary artery disease by diet control, stress reduction, exercise, and group interaction. Limited placements are available in the pilot program, which will begin in September. For more information, call 1 (800) 442-9300.

MMS Releases Inline, Skating Guide

At an August 2 news conference on the Boston Esplanade, the MMS released On Your Left, a new safety guide for inline skaters. A MMS InLine Task Force (with physicians and members of the MMS Alliance) worked with the InLine Club of Boston on the guide, the first developed by physicians. The guide provides information on proper safety equipment and skating tips to help skaters avoid accidents and injuries. "Inline skating is the fastest growing recreational sport here in Massachusetts and across the country," said Guenter L. Spanknebel, M.D., MMS president, at the news conference. "As physicians, we want all our patients who enjoy this sport to do so safely." According to the Consumer Product Safety Commission (CPSC), an estimated 105,000 inline skating-related injuries will require emergency room treatment this year, a 184 percent increase in such injuries over the past two years.

The MMS Inline Task Force noted that a study found that the likelihood of injury with the sport was associated with the skill level of the skater

and the use–or lack of–protective gear, including wrist, elbow, and knee guards, and helmets.

On Your Left grew out of a resolution approved by the MMS House of Delegates in November to promote the use of protective equipment by inline skaters and develop related legislation. As part of the promotional effort and to provide safety information to populations most at risk for inline injuries, the MMS will also send the brochure to national sporting magazines and other national publications. Inline Task Force members will be available to provide additional safety tips. Copies of the guide and an order form are enroute to primary care physicians, radiologists, sports medicine, and emergency room specialists; the general public can order individual copies of the guide with a self-addressed stamped envelope. Orders and inquires should be addressed to the MMS Department of Public Health, 1440 Main Street, Waltham MA 02154.

MASS TB Rates Decline

The Massachusetts Department of Public Health (DPH) reported late July that the rate of tuberculosis in the Commonwealth has fallen to its lowest point in more than 100 years. The DPH reported that although the TB rate is now fewer than 6 cases per 100,000 persons, some populations remain at high risk for the disease. Immigrants and homeless persons are still vulnerable to TB, the DPH warned, and emphasized that continued funding for TB hospital control clinics would be an important factor in the Commonwealth's continued ability to control the disease.

AG Considers New Regulations On Termination of Coverage

On July 10, the Society presented testimony before the Office of the Massachusetts Attorney General in support of proposed regulations concerning *termination of insurance coverage in instances of premium nonpayment.* The regulations would require health insurers to provide written notice to individuals covered under group policies that their policies are about to be canceled for nonpayment of premium. (Although the Attorney General's Office has reported approximately 100 complaints concerning group nonpayment of premiums, the situation presents serious problems for the previously insured patients.) The regulations also would require that any claim for service rendered prior to the notification would be honored, even if the policy were canceled.

In the current absence of such regulations, the Society testified, "physicians often find themselves in the distasteful and unenviable position

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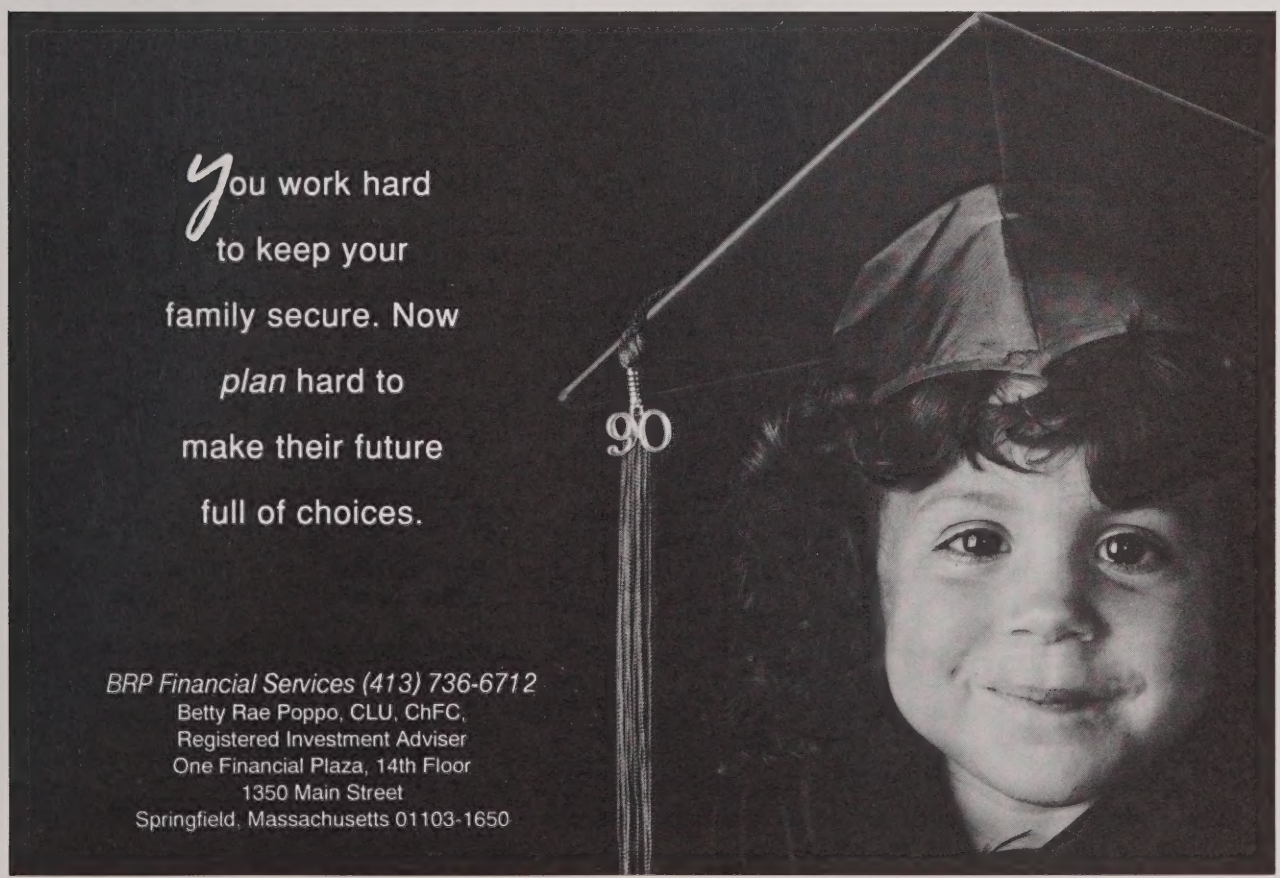

MMS Executive Briefs

Continued from previous page

of telling their patients that their health insurance has been canceled, which is usually the first time the patient has been made aware of the situation." The Society also noted that physicians and office staffs spend considerable time trying to investigate the problem for patients, time that could be more appropriately used to render medical care. The Massachusetts Hospital Association also testified in favor of the proposed regulations, which are opposed by the Massachusetts Association of HMOs.

MMS: Fix Barriers To Adolescent Care

Suffolk District Medical Society President Marian C. Craighill, M.D., testified on the need for greater health care services for adolescents at a *Blue Ribbon Commission on Health Care Reform/Subcommittee on Universal Coverage* hearing last week. Dr. Craighill, associate in gynecology at Children's Hospital, stressed the special needs of the adolescent population at the Subcommittee's July 10 hearing. She also described how the current fragmented health care delivery system, "riddled with gaps in coverage," affects adolescents, particularly 18-20 year olds. The Subcommittee is scheduled to report back with its recommendations to the full Committee in late August. The full Commission is focusing on the effects of implementing the Medicaid waiver in Massachusetts.

MMS Joins "Peace At Home" Campaign

The MMS helped to sponsor a June 3 public awareness television special on Fox 25 television that focused on the problem of *domestic violence* in Massachusetts. The program, part of the "Peace at Home" human rights organization's campaign against domestic violence, included the network premiere of "Defending Our Lives"; this documentary film about domestic violence victims in Massachusetts won the 1994 Academy Award. Proceeds from the program funded distribution of the Peace at Home educational handbook, *Domestic Violence: The Facts.* This handbook, written for the general public, provides information on warning signs of domestic violence, suggestions to assist victims and potential victims of violence, hotline and referral numbers, and other information. Complimentary copies of the handbook in different languages (English, French, Spanish) are available by contacting Peace at Home in Boston at (617) 482-1851 or FAX at (617) 482-6504. ■

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Premed: Wesleyan University, CT 1963-1971
Medical: New York Medical College 1989
Internship: Baystate Medical Center 1989-1990
Residency: Baystate Medical Center 1989-1994
Specialty: General Surgery

Theonia K. Boyd, M.D.
Baystate Medical Center
759 Chestnut Street
Springfield, MA 01199

Born: September 24, 1960
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Medical: University of Utah School of Medicine 1984-1988
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6. MMS Reports	____	____
7. AMA Meeting Reports	____	____
8. Pioneer Valley Grand Rounds	____	____
9. Practice Changes	____	____
10. HDMS Event Reports	____	____
11. Local Lawyers review of important and/or local medical cases	____	____
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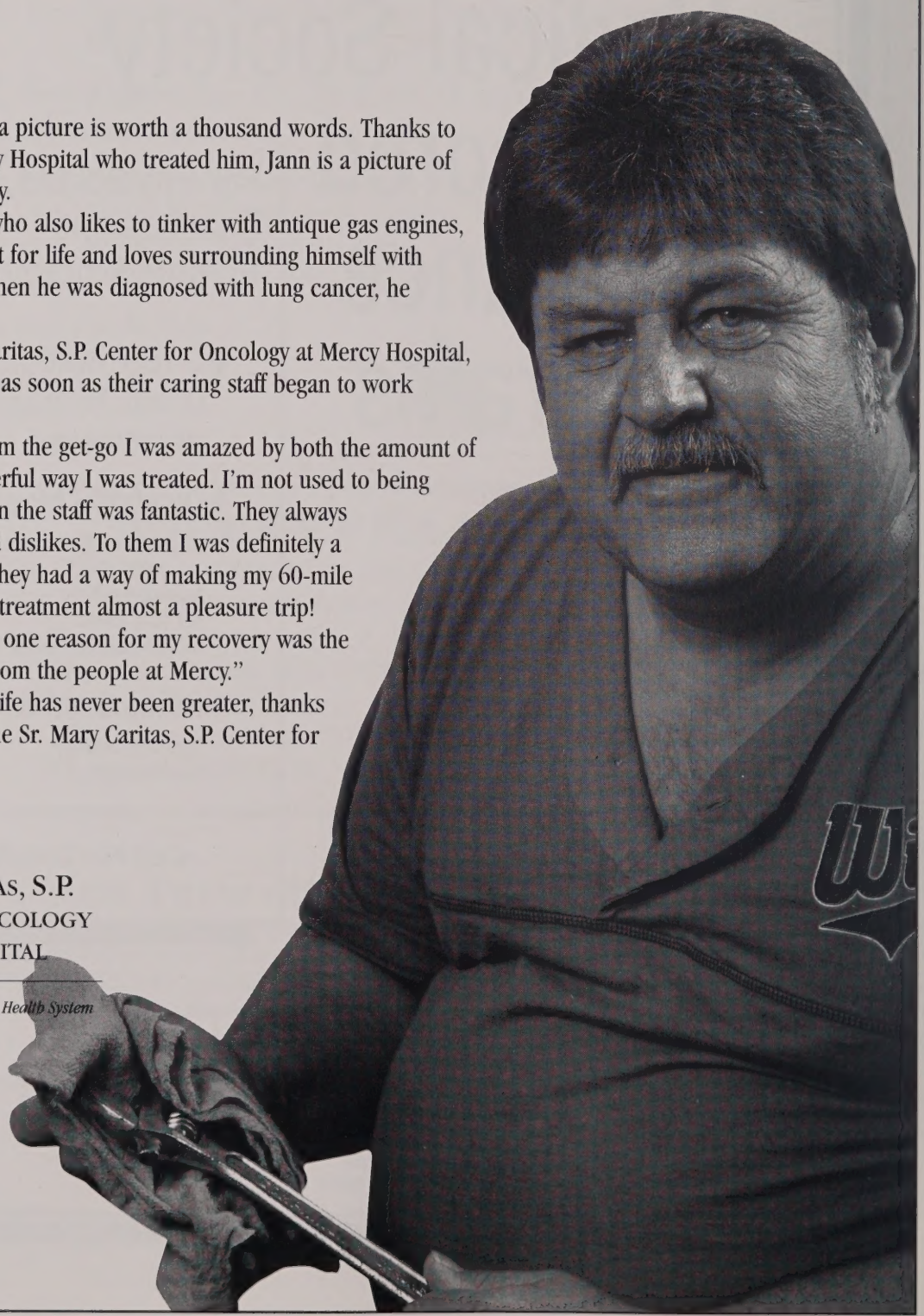
Jann noted, "Right from the get-go I was amazed by both the amount of technology and the wonderful way I was treated. I'm not used to being waited on, but everyone on the staff was fantastic. They always remembered my likes and dislikes. To them I was definitely a person—not a number. They had a way of making my 60-mile drive to get the necessary treatment almost a pleasure trip! Without a doubt, I believe one reason for my recovery was the incredible support I got from the people at Mercy."

Today, Jann's zest for life has never been greater, thanks to the caring support of the Sr. Mary Caritas, S.P. Center for Oncology.



SR. MARY CARITAS, S.P.
CENTER FOR ONCOLOGY
AT MERCY HOSPITAL

A member of the Sisters of Providence Health System

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